Question 1

Congress created the Ticket to Work program in 1999 to help beneficiaries return to work, but the number of beneficiaries who leave the rolls due to work is negligible. You support a fundamentally different approach, one in which ways are found to keep those with disabilities in the workplace for as long as possible. Please provide further details as to the best ways to do that?

Response 1

The vast majority of the evidence in the rehabilitation literature finds that the sooner rehabilitation and accommodation are provided, once medical treatments allow, following the onset of a work-limiting condition, the better is the chance of a return to work. This is the key insight that drives my views with respect to Social Security Disability Insurance reforms. We should be focusing on demonstrations of policy changes that can slow the movement of those with work limitations onto the SSDI rolls rather than tinkering with ways to improve the failed Ticket to Work Program or spending millions on demonstrations that, like the "2-for-1", belatedly attempt to encourage those who have often spent years demonstrating that they are unable to perform substantial gainful activity to work.

SSDI must return to being the last resort income-support program Congress originally intended it to be. In addition to the many changes that have been suggested to better determine who should be on the rolls and the best ways to handle the appeals process, we should be focusing on sending clearer signals to employers and their workers of the true cost of providing long term disability benefits to workers who come onto the SSDI system. The current flat rate payroll tax system of funding SSDI fails to do so.

An experience-rated system of funding SSDI, using the best practices of the various State Workers Compensation programs, would be one way to do so. Workers injured on the job are more likely to receive rehabilitation and accommodation than workers whose injuries are not job related, because employers know that their future Workers Compensation payment rates will be affected by how many of their workers receive benefits.

Furthermore, we know that about 30 percent of current workers are covered by private long-term disability insurance. When they experience a work limitation on or off the job, case managers are assigned to assess their work capacity and recommend accommodation and rehabilitation. Because firms must pay insurance companies higher premiums if their workers go onto their long-term benefits programs, they take an active interest in such case management. This is not the case for workers not covered by such insurance and they are more likely to come onto SSDI without any additional expense to their employers.

Experience rating SSDI benefits would require all employers to take a more active interest in working with private sector insurance providers to provide the case management up-front that is missing from our non-integrated private/public disability system. It is this lack of case management that is the flaw in our current disability system. It distinguishes us from all other OECD countries, most of whom manage cases at the government level. Rather than expanding the role of the Social Security System to provide this kind of case management, I believe it makes much more sense for the private sector to expand to do so, and experience rating SSDI is the least intrusive way to achieve this goal.

Question 2

Some support reallocating the payroll tax to address the Disability Insurance financing shortfall in the near-term, and saving significant reform efforts for later. What's your reaction to this approach?

Response 2

The SSDI Trust Fund is expected to run out in 2016. Papering over the fundamental flaws in the current SSDI program by borrowing from the OASI fund is no solution. While the Great Recession of 2007-2009 and its aftermath has greatly contributed to the share of the working-age population that has applied and been accepted onto the SSDI program since 2008, these numbers have been growing since 1990 and will not go back to 1990 levels once the economy fully recovers.

Program policy changes, not aging baby boomers or the increasing share of women covered by SSDI, are responsible for this program growth and only fundamental policy changes will bend back the future SSDI cost curve.

Question 3

Based on your testimony, it sounds as though the reforms to the Dutch system have been in place for about 10 years. Did the Dutch pilot this system first?

Response 3

To my knowledge there were no pilots of the Dutch reforms prior to their enactment. What drove them to action was a disability system that was out of control, and a willingness to recognize that the cause was policy-based not health-based.

Question 4

What have been the effects of the changes on the Dutch disability rolls? On Dutch employers? On the Dutch economy overall?

Response 4

The Dutch over the last decade have fundamentally reformed their runaway disability system by requiring all firms to take responsibility for the first two years of disability benefits and funding the first 10 years of payment for workers on their national disability program via experience-rated payments by firms.

As a result a major increase occurred in the private sector provision of disability insurance as Dutch firms more directly recognized the true costs of their employees going onto the disability benefit rolls. Private sector case management by private disability insurance companies is now the norm. As part of the reforms, workers are required by law to cooperate with these private case managers or forfeit their eligibility for government disability insurance once their two years of private sector benefits are up.

There are now several government-funded studies of the consequences of these program changes on the movement of workers from their short-term (sickness) programs to their long-term disability programs. Early results suggest that they have reduced movement onto the long-term government disability rolls and increased returns to work rather than simply shifting non-workers, who would have gone onto the long-term government disability rolls, onto some other welfare program.

The Dutch are no longer considered the "sick country of Europe." In fact, the OECD now points to the Dutch reforms as a model for other countries and Dutch disability beneficiaries per 1,000 workers has fallen substantially since the implementation of these reforms in the early 2000s. In fact, the U.S.A. now has higher ratios of beneficiaries to workers than the Dutch.

Question 5

If Congress were to authorize a pilot activity to get better data and practice as part of a strategy of disability reform, what would be the design elements that the pilot or pilots should be testing?

Response 5

The first key objective of any pilot or demonstration should be to determine the role that early intervention via case management would play in slowing the movement of a random sample of those experiencing a work limitation onto the SSDI program.

One idea would be to show how the provision of private sector case management to those who are coming onto the short-run disability insurance programs impacts their subsequent application and acceptance onto the SSDI program. For instance, this could be done in one of the States where short-term disability insurance is mandatory.

If that were successful I would then use a larger demonstration of policy changes that would provide incentives for increasing the use of private sector case management in slowing the movement of those with work limitations onto the SSDI rolls. My preferred policy change to test would be experience rating, since that was at the heart of the successful Dutch reforms. But another might be to lower payroll taxes for those firms who offer some minimum standard of private disability insurance that is more fully integrated into the SSDI system via the provision of medical records or other mechanisms to better provide uniform information to SSDI. But I would do this up-front rather than conditional on their actually lowering program costs.

But these are only some possibilities. I would urge Congress to fund a process that would systematically acquire such information by asking either the SSA, NIA or some other government-affiliated organization familiar with soliciting external research to put out a series of RFPs that would first seek the best methods for answering the key question:

What are the best mechanisms for slowing the movement of those with work limitations onto the SSDI rolls?

The next step would be to develop and implement demonstrations to test those methods.

But it would also be useful to look to the Dutch reforms as potential pilots for what works since they, more than any other OECD country, most resemble the U.S. system and have found the key to involving the private sector in case management.

Question 6

Unlike many other states, Nebraska's Disability Determination Section (DDS) is part of the Department of Education, not the Department of Health and Human Services. I am told by state officials this structure decreases external pressure on DDS to move beneficiaries off of state-funded programs onto the Social Security Disability Insurance Program and increases coordination with vocational rehabilitation programs. In your study of incentives underlying the disability program, have you had an opportunity to study operational incentives such as this? If so, what are your findings?

Response 6

I was not aware of this difference in agency authority in Nebraska. It is an interesting hypothesis that putting DDS and Vocational Rehabilitation in the same agency might make it more likely that some sort of government-centered case management would occur and hence lead to more effective use of rehabilitation and a slowdown of movement onto the SSDI rolls. This idea of government case management is the norm in most European countries. But I have not looked at this possibility at the state level and it is not done effectively at the federal level.